436.406(b) and 436.406(c) of this subchapter will only be provided the limited services specified in § 440.255.

[56 FR 24011, May 28, 1991, as amended at 58 FR 4938, Jan. 19, 1993]

§ 440.225 Optional services.

Any of the services defined in subpart A of this part that are not required under §§ 440.210 and 440.220 may be furnished under the State plan at the State's option.

[60 FR 19862, Apr. 21, 1995]

§ 440.230 Sufficiency of amount, duration, and scope.

(a) The plan must specify the amount, duration, and scope of each service that it provides for—

(1) The categorically needy; and

(2) Each covered group of medically needy.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

[46 FR 47993, Sept. 30, 1981]

§ 440.240 Comparability of services for groups.

Except as limited in § 440.250—

(a) The plan must provide that the services available to any categorically needy beneficiary under the plan are not less in amount, duration, and scope than those services available to a medically needy beneficiary; and

(b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all beneficiaries within the group:

(1) The categorically needy.

(2) A covered medically needy group.

[46 FR 47993, Sept. 30, 1981]

§ 440.250 Limits on comparability of services.

(a) Skilled nursing facility services (§ 440.40(a)) may be limited to beneficiaries age 21 or older.

(b) Early and periodic screening, diagnosis, and treatment (§ 440.40(b)) must be limited to beneficiaries under age 21.

(c) Family planning services and supplies must be limited to beneficiaries of childbearing age, including minors who can be considered sexually active and who desire the services and supplies.

(d) If covered under the plan, services to beneficiaries in institutions for mental diseases (§ 440.140) must be limited to those age 65 or older.

(e) If covered under the plan, inpatient psychiatric services (§ 440.160) must be limited to beneficiaries under age 22 as specified in § 441.151(c) of this subchapter.

(f) If Medicare benefits under Part B of title XVIII are made available to beneficiaries through a buy-in agreement or payment of premiums, or part or all of the deductibles, cost sharing or similar charges, they may be limited to beneficiaries who are covered by the agreement or payment.

(g) If services in addition to those offered under the plan are made available under a contract between the agency or political subdivision and an organization providing comprehensive health services, those additional services may be limited to beneficiaries who reside in the geographic area served by the contracting organization and who elect to receive services from it.

(h) Ambulatory services for the medically needy (§ 440.220(a)(2)) may be limited to:

(1) Individuals under age 18; and

(2) Groups of individuals entitled to institutional services.

(i) Services provided under an exception to requirements allowed under § 431.54 may be limited as provided under that exception.

(j) If CMS has approved a waiver of Medicaid requirements under § 431.55, services may be limited as provided by the waiver.

(k) If the agency has been granted a waiver of the requirements of § 440.240 (Comparability of services) in order to

provide for home or community-based services under §§440.180 or 440.181, the services provided under the waiver need not be comparable for all individuals within a group.

(l) If the agency imposes cost sharing on beneficiaries in accordance with 447.53, the imposition of cost sharing on an individual who is not exempted by one of the conditions in section 447.53(b) shall not require the State to impose copayments on an individual who is eligible for such exemption.

(m) Eligible legalized aliens who are not in the exempt groups described in §§435.406(a) and 436.406(a), and considered categorically needy or medically needy must be furnished only emergency services (as defined in §440.255), and services for pregnant women as defined in section 1916(a)(2)(B) of the Social Security Act for 5 years from the date the alien is granted lawful temporary resident status.

(n) Aliens who are not lawful permanent residents, permanently residing in the United States under color of law, or granted lawful status under section 245A, 210 or 210A of the Immigration and Nationality Act, who, otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI or a State Supplementary payment) must be furnished only those services necessary to treat an emergency medical condition of the alien as defined in §440.255(c).

(o) If the agency makes respiratory care services available under §440.185, the services need not be made available in equal amount, duration, and scope to any individual not eligible for coverage under that section. However, the services must be made available in equal amount, duration, and scope to all individuals eligible for coverage under that section.

(p) A State may provide a greater amount, duration, or scope of services to pregnant women than it provides under its plan to other individuals who are eligible for Medicaid, under the following conditions:

(1) These services must be pregnancy-related or related to any other condition which may complicate pregnancy, as defined in §440.210(a)(2) of this subpart; and

(2) These services must be provided in equal amount, duration, and scope to all pregnant women covered under the State plan.

(q) [Reserved]

(r) If specified in the plan, targeted case management services may be limited to the following:

(1) Certain geographic areas within a State, without regard to the statewide requirements in §431.50 of this chapter.

(2) Targeted groups specified by the State.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24889, Apr. 11, 1980; 46 FR 48541, Oct. 1, 1981; 48 FR 5735, Jan. 8, 1983; 51 FR 22041, June 17, 1986; 55 FR 36822, Sept. 7, 1990; 56 FR 24011, May 28, 1991; 57 FR 29156, June 30, 1992; 58 FR 4939, Jan. 19, 1993; 59 FR 37717, July 25, 1994; 72 FR 68092, Dec. 4, 2007]

§440.255 Limited services available to certain aliens.

(a) *FFP for services.* FFP is available for services provided to aliens described in this section which are necessary to treat an emergency medical condition as defined in paragraphs (b)(1) and (c) or services for pregnant women described in paragraph (b)(2).

(b) *Legalized aliens eligible only for emergency services and services for pregnant women.* Aliens granted lawful temporary resident status, or lawful permanent resident status under sections 245A, 210 or 210A of the Immigration and Nationality Act, who are not in one of the exempt groups described in §§435.406(a)(3) and 436.406(a)(3) and who meet all other requirements for Medicaid will be eligible for the following services—

(1) Emergency services required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(i) Placing the patient's health in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(2) Services for pregnant women which are included in the approved State plan. These services include routine prenatal care, labor and delivery, and routine post-partum care. States,